KENTUCKY STATE 30 J-1 VISA WAIVER PROGRAM
SPONSOR INFORMATION SHEET

This information sheet must be signed and dated by the sponsor and returned with all requested documentation by October 31 to:

KENTUCKY DEPARTMENT FOR PUBLIC HEALTH
DIVISION OF ADULT AND CHILD HEALTH
HEALTH CARE ACCESS BRANCH
ATTN: JOHN W. HENSLEY
275 EAST MAIN STREET, HS2GW-A
FRANKFORT, KENTUCKY 40621

J-1 PHYSICIAN _____ DOS CASE NUMBER_____

Name of Sponsoring Organization:_____

Address _____

City _____ County _____ Zip Code_____

Phone Number _____ Fax Number _____

Owner/ CEO /Manager Name _____

Services Provided _____

Hours and Days of Operation _____ Call Schedule: Yes No

HPSA or MUA designation and number _____

Information regarding the Service Site (if different from the Sponsoring Organization)

Name _____

Street Address_____
City _____Zip Code_____ Phone_____

Mailing Address _____
City _____Zip Code _____ Fax Number_____

Type of Organization: Private, For Profit ____ Private, Non Profit ____Public____

Substantiation of services to the underserved population

	1999	2000	2001
Number of total patients visits			
% of individuals not charged			
% Medicaid visits			
% Medicare visits			
% Sliding Fee Scale visits			
% Private Pay			

	1999	2000	2001
Number of Kentucky Physicians Care patients seen:			

Name of other J-1 Physicians at the practice site _____

Name of National Health Service Corps Physicians at practice site. _____

What is the location and average distance to the next nearest source of care comparable to the specialty of the J-1 Physician that is available to the clients of this practice site using available public transportation?

Proposed Schedule of J-1 Physician

WEEKDAY	**WORK HOURS**	**LOCATION**	**TOTAL HOURS**
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			

SPONSOR WAIVER AGREEMENT

I UNDERSTAND AND AGREE THAT I WILL

1. Provide a schedule for the physician to provide primary care services (family or general practice, pediatrics, internal medicine, or obstetrics/gynecology), psychiatry, or the approved specialty service on a full time basis (at least 40 hours per week) for at least three years in a Health Professional Shortage Area (HPSA) or a federally designated Medically Underserved Area/ Population (MUA/P) within ninety days of waiver issuance by the INS.
2. Obtain the approval of the Kentucky Department for Public Health prior to site changes of physician.
3. Participate in and accept assignment in the Medicare and Medicaid programs and continue to accept new Medicare and Medicaid patients up to the enrollment limits established by those programs. Notice of acceptance of Medicare and Medicaid will be posted in a conspicuous location.
4. Accept all patients regardless of method of payment or the ability to pay. The practice also agrees to establish a mechanism to reduce fees for individuals seen who have no health insurance coverage and whose income falls below 200% of the federally established poverty level. Notice of the availability of this discount will be posted in a conspicuous location. In addition, the practice agrees to participate in the Kentucky Physicians Care Program.
5. Submit a reporting form to the Kentucky Department for Public Health every six months or as often as requested by the Department.
6. Cooperate with Department staff with any site visits, which may be conducted.

I UNDERSTAND AND AGREE

1. The review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the department, any and all employees, agents and assigns from any action made in connection with this request.
2. The entire basis for the consideration of my request is the voluntary policy of the Department and its desire to improve the availability of needed medical care in regions designated by the United States Public Health Services as Health Professional Shortage Areas or Medically Underserved Areas.
3. The Department for Public Health shall not be a party to any contract or employment dispute between the sponsor and the physician. However, the Department shall be notified in the event of any change in the terms of the employment contract or premature termination of the contract.
4. I understand and acknowledge that if I willfully fail to comply with the terms of this J-1 Visa Waiver Agreement, the Kentucky Department for Public Health may elect not to consider my practice for future J-1 Visa Waiver recommendations.

SIGNATURE OF CEO/ OWNER_____ DATE _____

NOTARY _____ DATE _____